ARIZONA PIONEERS' HOME
REPORT OF ANNUAL EVALUATION
CONDUCTED BY
ARIZONA DEPARTMENT OF HEALTH SERVICES
SEPTEMBER 16, 2004

This is a report of the annual visit conducted at the Arizona Pioneers' Home to comply with A.R.S. 36-402, which states that, "This chapter or the rules adopted by the director pursuant to this chapter do not authorize the licensure, supervision, regulation or control of:

9. The Arizona pioneers' home. However, the department of health services shall evaluate the health and sanitation conditions at the Arizona pioneers' home annually using the standards applicable to licensed nursing care institutions. The department shall prepare and distribute reports of these visits to the president of the senate, the speaker of the house of representatives and the governor within thirty days of each visit. Reports shall include information as to the extent of compliance with applicable standards as compared to licensed nursing care institutions and recommendations for the improvement of care and services provided."

An unannounced visit was conducted to the Arizona Pioneers' Home by Catherine Corbin, MHS, Program Manager, Lise Rafferty, R.N., B.A., M.A., Team Leader, Susan Parry, R.N., BSN, Surveyor, and Dee Alana Terry, R.N., on September 13, 2004 through September 16, 2004, to evaluate the health and sanitation conditions at the Home. The following criteria were used for evaluation:

1. Chapter 10 Article 9 NCI Regulations.

2. Arizona Administrative Code Title 9, Chapter 10, pertaining to the licensure of Nursing Care Institutions.

<u>Persons contacted during the survey were:</u>

Jeanine Dike, R.N., Superintendent
Carl Johnson, Deputy Superintendent
Linda Fischer, R.N., Director of Nurses
Misty Rodarte, Social Services Director
Michael Holevar, Food Service Department
Lark Cyr, Activity Director

GENERAL OVERVIEW

The Arizona Pioneers' Home is located in Prescott, Arizona. It provides room, board and nursing services to 150 senior Arizona residents. The building comprising the Arizona Pioneers' Home was built in 1911.

FINDINGS

CORRECTIVE ACTION ACCOMPLISHED

The 2003 survey cited seventeen areas of non-compliance. Six of these seventeen areas were recited on the survey conducted September 16, 2004.

AREAS OF NON-COMPLIANCE

ADMINISTRATION

R9-10-904.
R9-10-904.D.
R9-10-904.D.4.

"An administrator shall ensure the nursing care institution's compliance with the fingerprinting requirements in A.R.S. 36-411."

Based on review of personnel records, the Pioneers' Home failed to comply with the fingerprinting standard and obtain fingerprint clearance cards for eight direct-care staff members (staff #1, #2, #3, #4, #5, #6, #7, and #8) in a sample of eight.

Staff #1 was hired on July 21, 2004, staff #2 was hired on July 26, 2004, staff #3 was hired on September 20, 2002, staff #4 was hired July 22, 2004, staff #5 was hired May 4, 2004, staff #6 was hired July 14, 2004, staff #7 was hired December 26, 2000, and staff #8 was hired September 19, 2001. The personnel records of these direct-care staff members did not have documentation of fingerprint clearance cards.

During an interview, an administrative staff member stated the Home did not have State funds allocated in order to comply with the fingerprinting requirements.

RECOMMENDATIONS:

Comply with the fingerprinting requirement for all direct-care staff working at the Arizona Pioneers' Home.

R9-10-904.
R9-10-904.E.
R9-10-904.E.9.
R9-10-904.E.9.b.
R9-10-904.E.9.b.i.

"An administrator shall ensure that the following are conspicuously posted on the premises: the name, address, and telephone number of the Department's Office of Long Term Care."

Based on observations, the Pioneers' Home failed to post on the premises the correct address and telephone number of the Department's Office of Long Term Care.

During observations on all days of the survey, the Home's bulletin board adjoining the dining room was found to contain a posting of the wrong address and telephone number of the Department's Office of Long Term Care.

RECOMMENDATIONS:

Post on the premises the name, address, and telephone number of the Department's Office of Long Term Care.

R9-10-904.
R9-10-904.E.
R9-10-904.E.9.
R9-10-904.E.9.e.

"An administrator shall ensure that the following are conspicuously posted on the premises: a copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect."

Based on observations during two of three days of the survey, the Pioneers' Home failed to have the last survey report with its plan of correction readily accessible to residents.

During a tour of the Home, a notice concerning the 2002 survey results was observed to be posted; however, the notice indicated that interested parties needed to ask for the survey results in the office of administrative staff. A copy of the 2003 survey results with its plan of correction that was in effect was not identified on this notice nor was it observed to be conspicuously posted on the premises.

During interview, administrative staff stated the 2003 survey had been posted, but that it had apparently disappeared.

RECOMMENDATIONS:

Prominently display a copy of the current survey report with the survey's plan of correction.

R9-10-904.
R9-10-904.F.
R9-10-904.F.6.

"If an administrator administers a resident's personal account at the request of the resident or the resident's representative, the administrator shall transfer all money from the resident's personal account in excess of $50.00 to an interest-bearing account and credit the interest to the resident's personal account."

Based on staff interviews and review of resident trust fund accounts, the Pioneers' Home failed to transfer from the personal account of residents, money in excess of $50.00, to an interest-bearing account.

Review of the most recent trust fund balance revealed that multiple residents had balances greater that $50.00 in their trust fund account.

During interview, administrative staff stated that while the resident funds account is kept separate from the Home's funds, the funds of the residents were not in an interest bearing account. Administrative staff stated that multiple residents had signed an acknowledgement form releasing the Home from the requirement of having their funds in an interest-bearing account.

RECOMMENDATIONS:

Transfer all money from the residents' personal account in excess of $50.00 to an interest-bearing account and credit the interest to the residents' personal account.

STAFF AND VOLUNTEERS

R9-10-905.
R9-10-905.B.
R9-10-905.B.2.

"An administrator shall appoint a full-time social worker if the nursing care institution has a licensed capacity of 120 or more."

Based on review of personnel records, the Pioneers' Home failed to ensure a qualified social worker was employed on a full-time basis.

Review of personnel records revealed that staff #7, hired on December 26, 2000, has been the appointed full-time social worker at the Home. While staff #7 has a baccalaureate degree, the degree is not in the areas as defined in State rules.

The State rules R9-10-901.88., R9-10-901.88.a., R9-10-901.88.b., and R9-10-901.88.c. define "Social worker" to mean an individual who has a baccalaureate degree in social work from a

program accredited by the Council on Social Work Education; has a baccalaureate degree in a human services field such as sociology, special education, rehabilitation counseling, or psychology; or is certified under A.R.S. Title 32, Chapter 33.

RECOMMENDATIONS:

Employ a qualified social worker on a full-time basis.

NURSING SERVICES

R9-10-906.
R9-10-906.B.
R9-10-906.B.13.
R9-10-906.B.13.a.

"A director of nursing shall ensure that a nurse shall, as soon as possible but not more than 24 hours after the event occurs, notify the resident's attending physician and, if applicable, the resident's representative, if the resident is injured."

Based on review of three closed clinical records and staff interview, the Pioneers' Home failed to ensure that for one resident (#12), the physician was notified when the resident was injured.

Resident #12 was admitted August 27, 2004, with diagnoses which included peripheral vascular disease, osteoarthritis, and macular degeneration.

A review of the nurse's notes disclosed that on August 31, 2004, the resident had fallen and fractured his hip. The note also documented that the family had been notified and an ambulance was called to transfer the resident to the hospital. The next nurse's note written the same day, at 7 p.m., documented that the resident was transferred to the hospital. There was no documentation that the resident's physician had ever been notified of his fall with an injury, nor was there any documentation that the physician had ordered the resident to be transferred to the hospital.

During an interview conducted on September 15, 2004 at 2:10 p.m., a staff member stated that there should have been an order from the physician to transfer the resident to the hospital.

RECOMMENDATIONS:

Notify the physician and obtain a physician's order when a resident is transferred to the hospital.

TRANSFER OR DISCHARGE

R9-10-909.
R9-10-909.C.
R9-10-909.C.1.
R9-10-909.C.1.b.

"Except in an emergency, a director of nursing shall ensure that before a resident is transferred or discharged a written plan is developed with the resident or the resident's representative that includes the state long-term care ombudsman's name, address, and telephone number."

Based on review of three closed clinical records, the Pioneers' Home failed to ensure that the state long-term care ombudsman's name, address and telephone number were provided to one resident (#10) being transferred.

Resident #10 was admitted on June 2, 2004, with diagnoses which included renal insufficiency, hyperlipidemia, mood disorder, anxiety, deep vein thrombosis, and depression.

A review of the resident's closed clinical record disclosed no documentation that the resident had been provided with the name, address, and telephone number of the state long-term care ombudsman, at the time of discharge.

RECOMMENDATIONS:

When a resident is transferred or discharged, develop a written plan with the resident or the resident's representative that includes the state long-term care ombudsman's name, address, and telephone number.

R9-10-909.
R9-10-909.C.
R9-10-909.C.2.
R9-10-909.C.2.a.

"Except in an emergency, a director of nursing shall ensure that before a resident is transferred or discharged a discharge summary is developed by a staff member providing direct care and authenticated by the resident's attending physician or designee."

Based on review of three closed clinical records, the Pioneers' Home failed to ensure that for one resident (#10), a discharge summary was developed by a staff member providing direct care and that the discharge summary was authenticated by the resident's attending physician or designee.

Resident #10 was admitted on June 2, 2004, with diagnoses which included renal insufficiency, hyperlipidemia, mood disorder, anxiety, deep vein thrombosis, and depression.

A review of the closed clinical record revealed that there was no documentation that a discharge summary had been developed by a direct care staff member and then signed by the attending physician.

RECOMMENDATIONS:

When a resident is transferred or discharged, a staff member providing direct care develops a discharge summary that is authenticated by the resident's attending physician or designee.

MEDICATION

R9-10-911.
R9-10-911.C.
R9-10-911.C.1.
R9-10-911.C.1.b.

"A director of nursing shall ensure that medication policies and procedures are established, documented, and implemented that include the administration, storage, and disposal of medications, biologicals, and controlled substances."

Based on clinical record review, staff interview, and review of the policy and procedures, the Pioneers' Home failed to ensure that three medications included dosage amounts on the physician's orders, for one resident (#4) in a sample of 12.

A review of resident #4's September 2004 Medication Administration Record (MAR) and physician's orders revealed the following medications were ordered on August 30, 2004:

-Sugar Free Tums as needed (PRN)
-Carbamide peroxide 6.5% ear drops for ear wax removal PRN.
-Flunisolide Nasal Saline 0.025% each nostril three times a day PRN.

A review of the policy and procedures on Medication Administration Record revealed documentation that physician orders were to be double checked and initialed by staff on two separate shifts.

During an interview conducted on September 14, 2004, licensed staff stated the staff member who took off these orders and placed them on the MAR did not realize that these orders did not have a dosage amount on them. Staff further stated that the staff member should have called the physician at that time to get a dosage amount for each of these medications ordered.

RECOMMENDATIONS:

Implement the administration of medications by clarifying dosages with the physician.

ENVIRONMENTAL AND EQUIPMENT STANDARDS

R9-10-915.
R9-10-915.1.
R9-10-915.1.b.

"An administrator shall ensure that a nursing care institutions's premises and equipment are free from a condition or situation that may cause a resident or an individual to suffer physical injury."

Based on random observations and staff interviews, the Pioneers' Home failed to ensure that the North and South Infirmary units were free of unsecured electrical cords, hazardous equipment and hazardous chemicals.

On all days of the survey on the South Infirmary unit, the following were observed:

-In room #'s 227 and 229, there were two residents' beds that had electrical cords loosely hanging from the wall outlet across the head of the bed's area. These cords were attached to various electrical items. One of the residents who occupied one of these beds stated that when she sleeps, these electrical cords bother her because she had to move them all the time when she repositions herself in bed.

During an interview conducted on September 15, 2004, maintenance staff stated that the residents' beds should not have had electrical cords hanging across them.

-In the main shower room, a Steam Pack Hydrocolator was observed to be placed on a bench. The exterior metal container of the Hydrocolator was found to be extremely hot to touch. Staff stated that the shower room door was never locked.

During an interview conducted on September 15, 2004, maintenance staff stated that the hydrocolator was too hot to be left in an unsecured room. He stated he did not know why the staff moved it from the dirty utility room were it was secured and unaccessible to residents.

-In the main shower room, on top of the linen cart, there were multiple 8-ounce containers of perineal cleaners and skin protectant creams that had warning labels that read "For external use only, Keep Out of Reach of Children if swallowed get medical help."

-In the hallway, another linen cart was stored by the south stairway and dining room. On top of this cart there were two plastic boxes that contained multiple 8-ounce containers of perineal cleaners and skin protectant creams that had warning labels that read "For external use only, Keep Out of Reach of Children if swallowed get medical help."

On all days of the survey, the following was observed in the tub room on the North Infirmary unit.

-Placed on a window ledge in the tub room, there were a 16-ounce bottle of baby shampoo with approximately 6 ounces remaining, a gallon jug of Hydro Soft tub cleaner with 1/2 gallon

remaining, and a gallon jug of skin and hair cleanser with 3/4 gallon remaining. All were uncapped and the caps were nowhere in sight. The labels on the jugs of Hydro Soft and skin and hair cleanser documented: "For external use only." The label on the bottle of baby shampoo documented: "Keep out of the reach of children."

-Placed on the floor next to the tub, there was a gallon bucket containing a cleaning solution, and on a table near the tub, there was a 12-ounce spray bottle of disinfectant. The label on this bottle documented: "Caution: Causes eye irritation." The label also documented that if the solution came in contact with the eyes, the eyes were to be rinsed with water and a physician was to be notified.

The door to the tub room was noted to be open at all times and was directly across from the men's ward where the door was also open at all times. Several of the men residing in this ward were cognitively impaired.

During a tour of the environment conducted on September 14, 2004, maintenance staff stated that personal care supplies that had warning labels on them, needed to be secured.

RECOMMENDATIONS:

Ensure that the Home's premises and equipment are free from a condition or situation that may cause a resident or an individual to suffer physical injury.

SAFETY STANDARDS

R9-10-916.
R9-10-916.A.
R9-10-916.A.4.

"An administrator shall ensure that a fire drill is performed on each shift at least once every three months."

Based on review of documentation and staff interview, the Pioneers' Home failed to ensure that a fire drill was conducted on each shift every three months.

A review of fire drill documentation revealed the following:

-There was no documented evidence that fire drills were conducted during the evening shifts (3-11) for the months of September 2003 through September 2004.

-There was no documented evidence that a fire drill had been conducted for the night shift (11-7) during the months of January, February and March 2004.

During an interview conducted on September 14, 2004, administration staff stated that they were unable to find any other fire drill documentation.

RECOMMENDATIONS:

Ensure that a fire drill is performed on each shift at least once every three months.

R9-10-916.
R9-10-916.A.
R9-10-916.A.5.

"An administrator shall ensure that a disaster drill is performed at least once every six months."

Based on review of disaster drills documentation and staff interview, the Pioneers' Home failed to conduct two disaster drills during the past year.

A review of disaster drill records revealed no documented evidence that any disaster drill had been conducted in the last year.

During an interview conducted on September 14, 2004, administration staff stated that they did not have any documentation that any disaster drill had occurred.

RECOMMENDATIONS;

Ensure that a disaster drill is performed at least once every six months.

R9-10-916.
R9-10-916.A.
R9-10-916.A.6.
R9-10-916.A.6.a.

"An administrator shall ensure that documentation of a fire drill required in subsection (A)(4) and a disaster drill required in subsection (A)(5) includes the date and time of the drill."

Based on review of fire drill documentation, the Pioneers' Home failed to ensure that nine of nine fire drills documented the time of day the fire drills were conducted.

A review of fire drill documentation revealed that nine fire drills were conducted the following months: October 17, 2003, December 18, 2003, January 22, 2004, February 26, 2004, March 25, 2004, April 15, 2004, June 22, 2004, July 16, 2004, and August 19, 2004. None of these fire drills documented the time of day the drill was conducted.

RECOMMENDATIONS:

Ensure that the fire drill documentation includes the date and time of the drill.

R9-10-916.
R9-10-916.A.
R9-10-916.A.6.
R9-10-916.A.6.b.

"An administrator shall ensure that documentation of a fire drill required in subsection (A)(4) and a disaster drill required in subsection (A)(5) includes the names of each staff member participating in the drill."

Based on review of fire drill documentation, the Pioneers' Home failed to ensure that three of nine fire drills documented the names of each staff member who participated in the drill.

A review of fire drill documentation revealed that three fire drills conducted on January 22, 2004, February 26, 2004, and March 25, 2004, did not include the names of each staff member who participated in the drills.

RECOMMENDATIONS:

Ensure that the fire drill and the disaster drill documentation includes the names of each staff member participating in the drill.

R9-10-916.
R9-10-916.A.
R9-10-916.A.6.
R9-10-916.A.6.c.

"An administrator shall ensure that documentation of a fire drill required in subsection (A)(4) and a disaster drill required in subsection (A)(5) includes a critique of the drill."

Based on fire drill documentation, the Pioneers' Home failed to ensure that three of nine fire drills documented a critique of the drill.

A review of fire drill documentation revealed that three fire drills conducted on December 18, 2003, January 22, 2004, and February 26, 2004, did not include a critique of the drill.

RECOMMENDATIONS:

Ensure that fire drill and disaster drill documentation include a critique of the drill.

R9-10-916.
R9-10-916.B.

"A fire safety inspection is conducted in the nursing care institution every 12 months by the fire authority having jurisdiction."

Based on review of documentation, the Pioneers' Home failed to obtain an annual fire safety inspection every twelve months.

Review of documentation revealed that the last annual fire safety inspection had been conducted more than twelve months ago.

During interview, administrative staff stated that the annual fire safety inspection was now planned to occur on September 22, 2004.

RECOMMENDATIONS:

Contact in a timely manner, the Office of the Arizona State Fire Marshall to schedule an annual fire inspection.

COMMENTS AND SUMMARY

Observations on all days of the survey, review of clinical records, and resident, family and staff interviews, revealed that the residents in the Pioneers' Home are cared for by caring and dedicated staff.

During the group interview with a dozen alert and oriented residents, there were consistent statements of appreciation for the services provided by the housekeeping, activity, social services, dietary, and nursing staff.

The following are of concern to the Department: failure to comply with the fingerprinting requirement for all direct-care staff working with vulnerable adults; failure to prominently display a copy of the current survey report with the survey's plan of correction; and failure to implement the administration of medications by clarifying dosages with the physician. Of further concern to the Department is the failure to contact in a timely manner, the Office of the Arizona State Fire Marshal to schedule an annual fire inspection.

The Pioneers' Home has sent a request to the Director, Catherine Eden, for a waiver on the issue of residents' personal account funds that are in excess of $50.00. Further, the Home is requesting to be exempt from the issue of a qualified full-time social worker. The Home maintains that the current acting social worker has a baccalaureate degree and is in the process of starting on post-graduate work in the field of Social Services. The Governor's office staff will determine whether a waiver is applicable with these two issues.

The Office of Long Term Care has offered to be available to the staff at the Arizona Pioneers' Home, and will provide any assistance the superintendent deems necessary.